



STRONGER COMMUNITIES. STRONGER AMERICA.

September 21, 2021

The Honorable Cheri Bustos
U.S. House of Representatives
1233 Longworth House Office Building
Washington, DC 20515

The Honorable Tom Cole
U.S. House of Representatives
2207 Rayburn House Office Building
Washington, DC 20515

The Honorable G.K. Butterfield
U.S. House of Representatives
2080 Rayburn House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
U.S. House of Representatives
2421 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Bustos, Cole, Butterfield, and Mullin:

On behalf of UnidosUS, I write to offer our recommendations as the new Social Determinants of Health Caucus considers potential opportunities to address social determinants, improve health outcomes, and maximize existing and future federal investments in health, food, and other important drivers of health.

UnidosUS, previously known as NCLR (National Council of La Raza), is the nation's largest Hispanic civil rights and advocacy organization. Through its unique combination of expert research, advocacy, programs, and an Affiliate Network of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic, and political barriers at the national and local levels.

The COVID-19 pandemic and economic crisis are severely impacting Latinos. Our community is more than twice as likely as non-Hispanic Whites to be hospitalized or die from the virus, and the Latino unemployment rate remains higher than the national rate overall.ⁱ Food insecurity among Latinos has also risen significantly, from a rate already disproportionately high prior to the pandemic.ⁱⁱ The pandemic has exposed and exacerbated long-standing disparities in our country, but is also providing a unique opportunity to rebuild a stronger, more equitable system.

Across numerous social determinants of health (SDOH)—including access to care, food insecurity, English proficiency, and others—Latinos face structural barriers that lead to disproportionately worse health outcomes.ⁱⁱⁱ We believe a whole-of-government approach is necessary to tackle these problems, yet one notable element is largely missing from the discussion of SDOH among ongoing federal efforts. While the Centers for Disease Control and Prevention (CDC) does recognize the intersection of immigration status and limited English proficiency (LEP) in its discussion of the latter's impact on health, its attention to immigration status as a separate and distinct SDOH is limited.^{iv} In our response below to the Request for

Information, we address how all of these factors affect Latinos' health, including the subset of Latinos who are immigrants, and recommend meaningful steps that Congress can take to address SDOH in an equitable and inclusive way that acknowledges immigration status as an SDOH on par with other determinants.

The U.S. Department of Health and Human Services (HHS) has undertaken many efforts in assigning responsibility to address SDOH to various offices within the Department, including through the *2020–2025 Federal Health IT Strategic Plan*, the CDC's Healthy People 2030 Initiative, and the Health Resources and Services Administration's (HRSA) Office of Health Equity.^v Through the Healthy People 2030 initiative, for example, the CDC aims to address the role that health care access, economic stability, nutrition and healthy eating, and other social factors play in a person's health. HRSA's Office of Health Equity also helpfully serves as principal advisor and coordinator for many populations, including Latinos and other racial and ethnic minorities. These efforts are laudable.

With further detail provided below, our top recommendations include:

- Formal recognition of immigration status as an SDOH and restoring access to public benefit programs
- Ensuring that all children have access to health coverage and remain enrolled
- Streamlining access to nutrition programs and ensuring that children have access year-round
- Expanding access to care, including for individuals with limited English proficiency (LEP)
- Collecting and making publicly available data disaggregated by race and ethnicity
- Eliminating barriers that prevent vulnerable Americans from accessing nutrition programs

Given the limited attention to immigration status as an SDOH, we answer some of the Request for Information's questions out of order to highlight this pressing issue.

Answers to Specific Questions from the Request for Information

Are there other federal policies that present challenges to addressing SDOH?

Immigration Status

Immigration status has an outsized impact on Latinos' ability to access the public benefits and services that are critical to addressing SDOH. The five-year bar was imposed under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This policy prevents lawful immigrants from accessing programs such as Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and

Temporary Assistance for Needy Families (TANF) during their first five years and is one of the most harmful policies impacting Latinos' health today.

While the so-called immigrant paradox purports to explain why recently arrived immigrants seem to enjoy better health than similarly situated native-born residents, research into the paradox has been complicated by contradictory findings, and conclusions vary depending on age at migration, undocumented status, and other factors.^{vi} One thing is clear, however: policies like the five-year bar prevent otherwise eligible lawful immigrant Latinos from turning to the same social safety net that all other Americans can rely on during difficult times.

The stratification of eligibility by an individual's immigration status has a demonstrable impact on families' and children's access to safety net programs. Child care subsidies, SNAP, and Earned Income Tax Credit (EITC) participation are all lower among eligible mixed-status or immigrant families than their citizen counterparts.^{vii} While the five-year bar has been lifted for children to receive SNAP, the bar's application to their parents may mean that benefits must be prorated to exclude their parents, unreasonably penalizing vulnerable children.^{viii}

Immigration status also serves as an SDOH in other ways, including by leading to higher levels of stress and discrimination. Aside from keeping eligible families from enrolling in programs that address health and social needs, the fear and anxiety resulting from uncertainty about one's immigration status or toxic anti-immigrant rhetoric can have a toll on an individual's mental health.^{ix} The psychological toll on Deferred Action for Childhood Arrivals (DACA) recipients, in particular when their status is in jeopardy, has been widely documented.^x

Stress, discrimination, and avoidance of public programs and services such as Medicaid/CHIP, SNAP, housing subsidies, and other benefits are closely interrelated, and the effects of these factors is widespread, particularly since 2017.^{xi} Such spillover effects are largely driven by families' anxiety and fear about the immigration consequences of availing themselves of these programs.

Moreover, the "chilling effect" that resulted from the revised public charge rule led to confusion that impacted access for immigrants as well as their eligible U.S. citizen children. After 2017, more restrictive immigration policies led to a trend of canceled appointments for uninsured Latino children, risking even greater health disparities for this population.^{xii} In 2019, less than 20% of immigrant parents knew that their children's enrollment in Medicaid, for example, would not have any impact on a parent's public charge determination.^{xiii}

Even more alarmingly, this avoidance continued throughout the pandemic—putting immigrant parents and their families in even greater jeopardy as they continued to show up to frontline and essential jobs.^{xiv} Even when federal officials made clear that benefits such as vaccines were

not restricted by immigration status, long-standing discriminatory policies and attitudes led some immigrants to avoid critical public health services.^{xv}

We recommend the following policies to address immigration status as an SDOH:

- **Formal recognition of immigration status as an SDOH has the potential to drive further downstream changes at the federal and state level.** Congressional leadership on this front would send an unmistakable signal to federal agencies and state policymakers that improving immigrant health, including that of millions of Latinos, is a priority. This would help lawful and undocumented immigrants and have meaningful spillover effects for U.S. citizen children living in mixed-status households. It would also elevate the visibility of immigration status as a factor influencing health and as a target for future funding initiatives by Congress through appropriations or other legislative vehicles, and for greater attention from administrative bodies like HHS’s SDOH Workgroup.
- **Repealing the five-year bar is one of the most significant changes Congress can make to account for this SDOH.** With the perspective we now have on PRWORA, it is clear that the restrictions it placed on lawful immigrants’ ability to access public benefits were unnecessary and discriminatory, creating a system of “qualified” and “nonqualified” immigrants that did not exist before.^{xvi} Congress already lifted the bar for children to access SNAP and gave states the ability to eliminate it for pregnant women and children to access Medicaid and CHIP in 2009. Half of states have already done so for pregnant women, and 35 have for children.^{xvii} Making this change would only restore access for lawful immigrants as it existed before 1996.

Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families?

Children’s Access to Health Coverage and Nutrition Programs

The long-term health and well-being of our country depends on adequately addressing SDOH for Latino children. Today, Latinos make up approximately 18% of the U.S. population, as well as one in every four children in the U.S., but by 2050, Latino children are expected to comprise one-third of the child population.^{xviii}

Latino children are in a precarious situation. It will require bold action by Congress to improve their health and well-being. Since 2017, the positive health coverage gains that Latino children experienced following enactment of the Affordable Care Act (ACA) began to reverse course— with Latino children’s uninsured rate rising from a low of 7.7% in 2016 to 9.2% in 2019.^{xix} By September 2021, Latino children accounted for approximately one-third of all COVID-19 cases

among children and approximately 30% of all COVID-19-related deaths.^{xx} The long-term health consequences of COVID infection remain uncertain, but preliminary evidence is alarming.^{xxi} The failures of our current system to adequately protect Latino children from this pandemic should be acknowledged as a tragedy and serve as a warning as we look ahead.

Adequately addressing the impact of SDOH on the lifelong trajectories of children will require ensuring that all children have access to the supports necessary to stay healthy. Latino children were already more likely to suffer from some conditions that exacerbated the impact of COVID-19, including obesity.^{xxii} Food insecurity is linked with higher rates of obesity among Latino children, and health coverage is essential for tackling the health problems that arise from this complex intersection of SDOH.^{xxiii}

We recommend several key policy changes that can help to ensure that all children have access to health care and nutritious food when they need it:

- **Ensuring that all children are eligible for health coverage programs, regardless of immigration status, and that they remain enrolled for at least 12 months are the most important policy changes Congress can make.** Sixteen states still apply the five-year bar to lawful immigrant children, and undocumented children remain largely ineligible for public health coverage (with few exceptions, such as states that provide coverage through state-only funding).^{xxiv} While 95% of Latino children are U.S. citizens, the barriers to coverage for lawful and undocumented children are discriminatory and harmful. Any serious commitment to tackling SDOH will fall short if it ignores the most straightforward way to improve children’s health: ensuring they have access to health coverage.

Even for those who are eligible and enrolled, “churn” poses a particularly serious threat for children. Churning on and off of public coverage due to complex and confusing state renewal procedures causes children to receive fewer prescriptions, experience delayed care, and be less likely to have a usual source of care.^{xxv} In Texas, one report found that parents missing the 10-day window for a renewal response accounted for more than 90% of coverage losses among children between 2017 and 2019.^{xxvi} Requiring all state Medicaid and CHIP programs to continuously cover children for at least 12 months would go a long way toward improving Latino children’s health.

- **Streamlining enrollment in school lunch and breakfast for children already eligible for or enrolled in programs with similar income requirements will simplify the process for schools and parents.** States can already directly certify children receiving SNAP for school meals due to similar income-eligibility requirements. Still, Latinos are far less likely than similarly eligible and needy non-Hispanic Whites to participate in SNAP, while

far more Latino children are enrolled in Medicaid than in SNAP.^{xxvii} In order to ensure that all children in need are receiving the meals for which they qualify, Congress should directly certify children enrolled in or eligible for programs with similar eligibility requirements (e.g., Medicaid) for school lunch and breakfast.

- **Making the Summer Electronic Benefit Transfer for Children (Summer EBT) program permanent would ensure that children have access to nutritious food all year.**

Children’s nutritional and food security needs do not end with the school year. Congress wisely created the Pandemic EBT program last year to ensure that school disruptions wouldn’t prevent children from receiving free or reduced-price meals. The Summer EBT demonstration project has proven its effectiveness by reducing the most severe category of food insecurity among children during the summer by one-third.^{xxviii} With increased access to nutritious food, low-income children are less likely to gain weight during summer or to face increased risk of related conditions such as obesity and diabetes (problems with which Latino children already struggle).^{xxix} While Congress has proposed an extension of the Summer EBT program through Budget Reconciliation, using future legislative vehicles to make it permanent is an important step that Congress can take to address Latino children’s health and food security.

What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve?

Access to Care, Including for LEP Individuals

Expanding access to health care is one of the most straightforward levers available to Congress to address gaps and improve Latinos’ health. Researchers and public health

programs have long recognized that access to health care is one of the clearest SDOH.^{xxx} Without adequate access to quality and affordable health care, people struggle to address and alleviate health problems influenced by other social determinants, for example, poverty, food insecurity, or poor housing. In the U.S., health care access is strongly linked to health coverage rates, and uninsured people are far less likely to report a usual source of care and more likely to report postponing care due to cost.^{xxxi} Prior to the pandemic, more than 26 million people did not have health insurance at any point in 2019, and another 40 million were underinsured, due to the barriers created by deductibles and other cost-sharing.^{xxxii}

Lack of access to care is an SDOH that disproportionately affects Latinos. While the uninsured rate for Latinos decreased following the implementation of the ACA (from around 30% in 2013 to 18.9% in 2017), these gains began to come undone since 2017. Today, Latinos are still significantly less likely than non-Hispanic Whites to report a usual source of care (58.2% vs. 77%). Latinos also continue to avoid care due to cost at higher rates than non-Hispanic Whites,

though the size of this effect varies depending on whether the state in which they live has expanded Medicaid or not, showing that it is directly related to cost considerations.^{xxxiii} Similarly, Latinos in non-expansion states are 8% more likely to lack a usual source of care than are Latinos in expansion states.^{xxxiv}

Notably, parental coverage can also produce important spillover effects for children in the same family. For example, expansion of coverage to more adults increases the likelihood that children in low-income families will receive more well-child visits.^{xxxv}

Limited English proficiency (LEP) creates a distinct barrier for many Latinos to access health care, resulting in a significant impact on their health and well-being. More than 41 million Americans speak Spanish at home, and more than 25 million people overall have LEP.^{xxxvi} As with other populations, the ACA improved coverage rates for LEP individuals, but people who do not speak English remain more than five times more likely to be uninsured than those who speak English “very well.”^{xxxvii} Even today, nearly 60% of Latinos report that they experience difficulties communicating with a health care provider due to either a language or cultural barrier.^{xxxviii}

Linguistically competent care is essential to delivering quality care by improving a patient’s ability to adhere to a prescribed course of treatment, reducing readmissions, and leading to fewer adverse health events. For example, Latinos have higher rates of hypertension than non-Hispanic Whites, but LEP is also a demonstrated driver of poorer health outcomes for patients with hypertension.^{xxxix} LEP Latinos with diabetes also experience better health outcomes when they are treated by bilingual or Spanish-speaking primary care providers.^{xl} Yet our current system lacks sufficient guardrails to ensure language access and that interpretation services are available to all people.

We recommend the following policies to expand access to care:

- **Fully reimbursing providers through Medicaid and CHIP for expenses attributable to language access services can help improve care for LEP individuals.** Translation and interpretation services currently can be reimbursed as part of administrative expenses or as an optional covered expense. States do not have to reimburse providers for the cost of language services, but under the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in 2009, states were given the option to claim a higher matching rate for translation/interpretation services. The CHIPRA increase to 75% should be expanded and include all individuals receiving these services under Medicaid. Only 15 states reimburse providers for language services via Medicaid or CHIP.^{xli} As it stands under current law, some providers receive such low reimbursement rates that they may lose money by seeing LEP patients.^{xlii} The lack of reimbursement is a barrier to

providing these services, particularly for community health centers that serve large shares of immigrant and LEP patients.^{xliii}

- **Creating a new grant program for states and localities to design and implement innovative, cost-effective programs to improve culturally and linguistically competent care can also improve the health of LEP individuals.** Grant recipients could develop formal and informal health literacy and English proficiency assessments, as well as simplifying and improving self-management tools and strategies. To maximize community input, grants should be targeted to programs that will facilitate partnerships with organizations that are already serving communities with limited English proficiency. The “Health Equity and Accountability Act of 2020” provides one model worthy of support. It proposes a pilot grant program to fund statewide efforts that provide on-site medical interpreting services under Medicaid.^{xliiv}

Data Disaggregated by Race and Ethnicity

One of the biggest gaps serving as a barrier to adequately understanding SDOH and developing policies to address them is the lack of public health data disaggregated by race, ethnicity, and other important demographic factors. We have seen the impact of limited available data throughout the pandemic, as federal and state governments operated based on incomplete COVID-19 case data and vaccination rates. Investments in culturally and linguistically competent care and services also require accurate data on language use, ethnicity, and country of origin.

Earlier this year, UnidosUS partnered with other racial and health equity organizations to release a series of recommendations related to this important policy priority.^{xliv} In addition to these, we recommend the policies listed below:

- **Collecting and making public all existing public health data, disaggregated by race and ethnicity, is essential.** The “Health Equity and Accountability Act of 2020” would require all federal agencies that collect disaggregated data on race, ethnicity, and other demographic factors to submit the data to a centralized electronic repository on the well-being of the U.S. population and prepare data for public use that relate to disparities in health status, access, quality, and outcomes.^{xlvi} Making the existing data more easily available and accessible is a first key step to ensuring that policymakers and advocates have tools they need to address SDOH.
- **Providing funding to Hispanic-serving institutions, historically Black colleges and universities, and other minority-serving institutions to access and analyze race,**

ethnicity, and other health disparity data would help improve the effectiveness of policy interventions. Along various health metrics (whether quality improvement or reducing health disparities), having access to timely data is essential to identifying and quantifying disparities, ensuring that existing policies achieve their stated goals, and improving health. Most importantly, any effort to advance health equity through new policies will fall short without accurate data. Funding analysis and research at minority-serving institutions is an invaluable step toward addressing SDOHs that disproportionately impact these populations.^{xlvii}

Access to Healthy Food

Food insecurity is a clear SDOH that disproportionately impacts Latinos. Prior to the pandemic, Latinos were more likely than non-Hispanic Whites to be food insecure.^{xlviii} This is especially true for Latino children. Prior to COVID-19, 17% of Latino children lived in food-insecure households compared to less than 11% of non-Hispanic White children.^{xlix} As a result, Latinos relied on programs such as SNAP, school lunch and breakfast programs, and the Supplemental Program for Women, Infants, and Children (WIC) in large numbers. Prior to COVID-19, Latinas and their children accounted for more than 40% of WIC participants.^l

The pandemic has only exacerbated this problem: 40% of Latino households with school-age children are now food insecure. Latino parents are more than three times as likely to report being worried about having enough to eat in the next month compared to non-Hispanic Whites.^{li} Preliminary data suggests that the nutrition gap between Latino families and the average American family has widened from 4% at the start of the pandemic to 6.8% today.^{lii} Early analysis also suggests that food insecurity can leave individuals—particularly children—more susceptible to infection.^{liii}

Food insecurity has predictable consequences for individuals' health. Poor access to nutritious food can lead to adverse birth outcomes and higher-risk pregnancies, obesity in children and adults, hypertension, diabetes, and other health conditions.^{liv} Latinos suffer from higher rates of many of these conditions, in part due to their higher rates of food insecurity and lack of access to affordable and nutritious food. Alleviating the influence of this social determinant is one of the most direct ways that policymakers can improve Latinos' health.

We recommend the following policy to help close the gap in food security:

- **Eliminating the three-month time limit for able-bodied adults to access SNAP benefits will improve Latinos' health and financial security.** Poverty, food insecurity, and health are closely interconnected.^{lv} Under current law, most able-bodied adults who are not working or enrolled in a training program for at least 20 hours a week are generally

prevented from receiving more than three months of SNAP benefits over a 36-month period. In 2009, as a result of the Great Recession, Congress suspended the three-month time limit due to the economic crisis and the increased need. For many states, it was not reinstated until 2016, only to be suspended again under the Families First Coronavirus Response Act due to COVID-19. Evidence shows that the time limit does not have significant effects on employment (its stated objective) but that it does have a negative impact on SNAP participation.^{lvi} Following the Great Recession, in 2015, SNAP lifted at least 1.2 million Latinos out of poverty.^{lvii} In a year when the Latino unemployment rate remains persistently higher as a result of the economic crisis, any strategy to address SDOH must lessen the burden imposed by work requirements and permanently eliminate this policy that fails to achieve its own stated goal.

We appreciate the leadership demonstrated by the co-chairs of the new Social Determinants of Health Caucus and the opportunity to share our recommendations on this very important topic. The pandemic and economic crisis have only further highlighted the need to account for the factors that influence individuals' health and to design policies that address gaps in our current system. Congress has an incredible opportunity to tackle many long-standing problems in health, nutrition, housing, and other SDOH. We look forward to working with the new Caucus to achieve our shared goals for our community and country.

Please contact Matthew Snider, Senior Health Policy Analyst, at msnider@unidosus.org with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Eric Rogriguez', with a stylized flourish at the end.

Eric Rogriguez
Senior Vice President, UnidosUS

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